OUTCOME REVIEW

State Form 51838 (8-04) / BCD 0110

Name of child	Date of birth (*month, day, year*)	County

☐ Six month review ☐ Other planned review

Date of IFSP (*month, day, year*)

OUTCOME REVIEW (*This page should be duplicated as needed, per review.*)
A review of the IFSP must be conducted at least every six months, earlier if the family requests a review, to determine the degree of progress toward achieving outcomes and whether modification or revision of the outcomes or services is necessary. Parents and other participants must receive 10-day prior written notice of meetings.

Statement regarding transition planning (*for each review*)

Outcome # ________ Progress Summary	MODIFICATIONS TO OUTCOME	CHANGE IN STRATEGY TO BETTER MEET OUTCOMES
	☐ Achieved ☐ Continue as written ☐ New outcome written (*see attached*) ☐ No longer a concern ☐ Other ________________________	☐ New strategy written ☐ Increase service ☐ Decrease service ☐ Other ________________________

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I / We participated in the IFSP review process and agree with the revisions reflected in this modification section. **An increase in an existing service or the addition of a new service will require the signature of my child's Primary Care Physician.**

Signature of parent	Date (*month, day, year*)	Signature of service coordinator